



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box
#15

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Date Received

MAY 19, 2006

MFDR Tracking Number

M4-06-6031-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated June 9, 2006: "The Carrier also did not make a legal denial of reimbursement when it did take final action on the medical bills because it did not provide payment exception codes required by the Division's Rules and instructions and Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration... Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below \$40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above \$40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the \$40,000 stop-loss threshold is reached...In this instance, the audited charges that remained after the last bill review by the insurance Carrier **\$40,010.51**. Using the Stop Loss Method, the total amount that Vista Medical Center Hospital should have been reimbursed for the services it provided was **\$30,007.88**. The prior amounts paid by the Carrier were **\$1,198.00**. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation reimbursement amount of **\$28,019.88**, plus any and all interest applicable."

Amount in Dispute: \$28,019.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated June 20, 2006: "The hospital fee guideline proves two criteria that must be met for a bill to be reimbursed under this section: (i.) the total audited charge for a hospital admission must exceed \$40,000 AND (ii.) the admission must be one that required 'unusually extensive services.' The stop-loss method should not apply to patients that did not require unusually costly or extensive services, even if the total audited charges exceed \$40,000...Also, all methods of determining reimbursement must meet the statutory requirement set forth in the Texas Labor Code Sec. 413.011 (d) '**Guidelines for medical service fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.**' It is Carrier's position they have correctly reimbursed the provider using the per diem methodology and no additional reimbursement should be made."

Response Submitted by: The Hartford

Respondent's Supplemental Position Summary Dated March 5, 2013: "This matter involves a disputed claim for additional reimbursement under the 1997 Acute Care Inpatient Hospital Fee Guideline...To be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that total audited charges exceed

\$40,000 and that an admission involved unusually costly and unusually extensive services...**The Admission At Issue Did Not Involve Unusually Costly And Unusually Extensive Services**... In short summary, an unremarkable hospital stay involving the exact services anticipated and nothing beyond routine post-operative care, by definition, does not trigger or qualify for reimbursement per the stop-loss exception...The 'unusually extensive' element of stop loss is nowhere to be found. Additionally, there is no evidence that the services provided were 'unusually costly'...No additional payment is due."

Response Submitted by: Downs-Stanford, PC

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 4, 2005 through October 5, 2005	Inpatient Hospital Services	\$28,019.88	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
4. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W1 – WORKERS COMP STATE FEE SCHED ADJUST. SUBMITTED SERVICES WERE REPRICED IN ACCORDANCE WITH STATE PER DIEM GUIDELINES.
- REIMBURSEMENT FOR PROCEDURE WAS WITHHELD DUE TO A PREVIOUS SUBMISSION.
- W1 – WC STATE FEE SCHED ADJUST. SUBMITTED SERVICES ARE CONSIDERED INCLUSIVE UNDER THE STATE PER DIEM GUIDELINES.
- W1 – WC STATE FEE SCHED ADJUST. REIMBURSEMENT ACCORDING TO THE TEXAS MEDICAL FEE GUIDELINES.
- 18 – DUPLICATE CLAIM/SERVICE. DUPLICATE CHARGES.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed \$40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges

exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals’ November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection...” 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The requestor in its position statement asserts that “The Carrier also did not make a legal denial of reimbursement when it did take final action on the medical bills because it did not provide payment exception codes required by the Division’s Rules and instructions and Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration.” 28 Texas Administrative Code §133.304(c), 17 Texas Register 1105, effective February 20, 1992, applicable to dates of service in dispute, states, in pertinent part, that “At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission’s instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier’s action(s). A generic statement that simply states a conclusion such as ‘not sufficiently documented’ or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section.” Review of the submitted documentation finds that the explanation of benefits were issued using the division-approved form TWCC 62 and noted payment exception codes “W1 and 18.”

These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier’s action(s). The Division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states “...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, (A) (v) of that same section states “...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed...” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$40,010.51. The Division concludes that the total audited charges exceed \$40,000.
3. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The Third Court of Appeals’ November 13, 2008 opinion states that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services” and further states that “...independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” The requestor in its position statement states that “Carrier may reimburse at a ‘per diem’ rate for the hospital services if the total audited charges for the entire admission are below \$40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above \$40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the \$40,000 stop-loss threshold is reached.” This statement does not meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C) because the requestor presumes that the disputed services meet Stop-Loss, thereby presuming that the

admission was unusually extensive. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).

4. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. Neither the requestor's original nor its supplemental position statement address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(6).
5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was one day. The surgical per diem rate of \$1,118 multiplied by the length of stay of one day results in an allowable amount of \$1,118.00.
 - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed \$302.85/unit for Thrombin 5,000 unit and \$289.00/unit for Dilaudid PCA 100ML. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is \$1,118.00. The respondent issued payment in the amount of \$1,988.00. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	05/10/2013 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.